DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HEALTH AND RECOVERY SERVICES ADMINISTRATION
Olympia, Washington

To:	Pharmacists All Prescribers Nursing Home Administrators Managed Care Organizations	**Memorandum No: 06-03** **Issued:** January 30, 2006 **For information, contact Provider Relations at:** 800.562.3022 or
From:	Douglas Porter, Assistant Secretary Health and Recovery Services Administration (HRSA)	http://maa.dshs.wa.gov/contact/prucontact.asp or visit the pharmacy web site at: http://maa.dshs.wa.gov/pharmacy

Subject: **Prescription Drug Program: New Drug Initiative Minimizing Therapeutic Duplication of Second-Generation Antidepressants, Changes to EPA, and Additions to the list of Limitations on Certain Drugs**

Effective for claims with dates of service on and after March 1, 2006, unless otherwise noted, HRSA will implement the following changes to the Prescription Drug Program:

- Require prior authorization for pharmacy claims for therapeutic duplication(s) of second-generation antidepressants when the duplication(s) exceed 68 days;
- Add a drug to the Expedited Prior Authorization (EPA) list and simplify the criteria associated with EPA code 006; and
- Set utilization limits on additional drugs (add to the list of Limitations on Certain Drugs).

New Drug Initiative: Minimizing Therapeutic Duplication of Second-Generation Antidepressants

Washington Medicaid is implementing a program to reduce the unnecessary duplication of therapy with second generation antidepressants which share the same or similar mechanisms of action. It is routine to have a client on more than one antidepressant in the process of changing medications, while tapering from one medication and starting another. This process can take as long as two months, but after that it is inadvisable to maintain a client on duplicative therapies. Multiple antidepressants with the same or similar mechanisms of action are likely to cause increased side effects with little or no increase in efficacy. In fact, it is possible for the drugs to compete, interfering with the efficacy of either or both drugs.

For this reason, HRSA has relied on mental health experts attending HRSA's Mental Health Drug Initiatives Stakeholder Workgroup to determine which therapies are duplicative in action. Based on this Workgroup's determination, HRSA now requires prior authorization (PA) for duplication of therapy in these classes that has lasted longer than a two-month taper period (68 days). The chart on the next page is a cross-reference of drugs the Workgroup has determined to be duplicative. The squares marked with "PA" indicate the combinations that will require PA after 68 days of concurrent therapy.

Effective for claims with dates of service on and after March 1, 2006, HRSA will allow pharmacy claims for therapeutic duplications of second-generation antidepressants for 68 days only. Any claim(s) for therapeutic duplication(s) that exceed 68 days will require PA. To request PA, fax HRSA at 360.725.2141 or call 800.848.2842 (option 1). In recognition of the tapering period, HRSA will authorize the prescription for two months. During the next two months, HRSA will work with the prescribing provider(s) to resolve the duplication therapy conflict or review clinical information that justifies its continuation.

Note: The boxes below marked with "PA" indicate the combinations that will require PA after 68 days of concurrent therapy.

Class	SSRI	NaSSA	NDRI	SARI	SNRI
SSRI	PA			PA	PA
NaSSA		PA		PA	
NDRI			PA		
SARI	PA	PA		PA	
SNRI	PA				PA

Legend:

- **SSRI** - (Selective Serotonin Reuptake Inhibitor such as fluoxetine, citalopram, escitalopram, fluvoxamine, paroxetine, and sertraline)
- **NaSSA** - (Noradrenergic and Specific Serotonergic Antidepressant such as mirtazapine)
- **NDRI** - (Norepinephrine/Dopamine Reuptake Inhibitor such as bupropion)
- **SARI** - (Serotonin Antagonist Reuptake Inhibitor such as nefazodone)
- **SNRI** - (Serotonin Norepinephrine Reuptake Inhibitor such as duloxetine and venlafaxine)

Expedited Prior Authorization (EPA) Addition

Effective the week of March 6, 2006:

Drug	Code	Criteria
Xopenex HFA® *(levalbuterol tartrate)*	044	All of the following must apply: a) Patient is 6 years of age or older; and b) Diagnosis of asthma, reactive airway disease, or reversible airway obstructive disease; and c) Must have tried and failed racemic generic albuterol; and d) Patient is not intolerant to beta-adrenergic effects such as tremor, increased heart rate, nervousness, insomnia, etc.

Expedited Prior Authorization (EPA) Changes

Effective the week of March 6, 2006:

Drug	Code	Criteria
Ambien®/ CR (*zolpidem tartrate)* Lunesta® *(eszopiclone)* Rozerem® *(ramelteon)* Sonata® *(zaleplon)*	006	Treatment of insomnia. Drug therapy is limited to 10 units in 30 days.

Additions to the List of Limitations on Certain Drugs

Drug	Limitations
Lunesta® 1 mg *(eszopiclone)*	3 per day and maximum 10 units in 30 days
Lunesta® 2 mg & 3 mg *(eszopiclone)*	1 per day and maximum 10 units in 30 days
Risperdal Consta® *(risperidone microspheres)*	1 unit per 14 days
Rozerem® 8 mg *(ramelteon)*	1 per day and maximum 10 units in 30 days

To view MAA's current list of Limitations on Certain Drugs, go to:
http://maa.dshs.wa.gov/pharmacy/DrugAuth.htm

Billing Instructions Replacement Pages

Attached are replacement pages H.7-H.10, H.13-H.14, and H.19-H.20 for HRSA's current *Prescription Drug Program Billing Instructions*.

How do I conduct business electronically with HRSA?

You may conduct business electronically with HRSA by accessing WaMedWeb at https://wamedweb.acs-inc.com.

How can I get HRSA's provider issuances?

To obtain HRSA's provider numbered memoranda and billing instructions, go to HRSA's website at http://maa.dshs.wa.gov (click on the ***Billing Instructions/Numbered Memoranda*** or ***Provider Publications/Fee Schedules*** **link**).

To request a free paper copy from the Department of Printing:

1. **Go to: www.prt.wa.gov** (Orders filled daily.)

   a) Click ***General Store***.

   b) If a **Security Alert** screen is displayed, click **OK.**

      i. Select either ***I'm New*** or ***Been Here***.
      ii. If new, fill out the registration and click ***Register***.
      iii. If returning, type your email and password and then click ***Login***.

   c) At the **Store Lobby** screen, click ***Shop by Agency***. Select ***Department of Social and Health Services*** and then select ***Health and Recovery Services Administration*.**

   d) Select ***Billing Instructions, Forms, Healthy Options, Numbered Memo, Publications,*** or ***Document Correction***. You will then need to select a year and then select the item by number and title.

2. **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX (360) 586-6361/ telephone (360) 586-6360. (Orders may take up to 2 weeks to fill.)

Drug	Code	Criteria
Abilify® *(aripiprazole)*	015	All of the following must apply: a) There must be an appropriate DSM IV diagnosis; and b) Patient is 6 years of age or older.
Accutane® *(isotretinoin)*		Must not be used by patients who are pregnant or who may become pregnant while undergoing treatment. The following conditions must be **absent**: a) Paraben sensitivity; b) Concomitant etretinate therapy; and c) Hepatitis or liver disease.
	001	Diagnosis of severe (disfiguring),recalcitrant cystic acne, unresponsive to conventional therapy.
	002	Diagnosis of severe, recalcitrant acne rosacea in adults unresponsive to conventional therapy.
	003	Diagnosis of severe keratinization disorders when prescribed by, or in consultation with, a dermatologist.
	004	Prevention of skin cancers in patients with xeroderma pigmentosum.
	005	Diagnosis of mycosis fungoides (T-cell lymphoma) unresponsive to other therapies.
Adderall® *(amphetamine/ dextro-amphetamine)*	026	Diagnosis of Attention Deficit /Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and the prescriber is an authorized schedule II prescriber.
	027	Diagnosis of narcolepsy by a neurologist or sleep specialist, following documented positive sleep latency testing and the prescriber is an authorized schedule II prescriber.
	087	Depression associated with end-stage illness and the prescriber is an authorized schedule II prescriber.

Drug	Code	Criteria
Adderall XR® *(amphetamine/ dextro-amphetamine)*	094	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and all of the following: a) The prescriber is an authorized schedule II prescriber; and b) Total daily dose is administered as a single dose.
Aggrenox® *(aspirin/dipyridamole)*	037	To reduce the risk of stroke in patients who have had transient ischemia of the brain or completed schemic stroke due to thrombosis, and all of the following: a) The patient has tried and failed aspirin or dipyridamole alone; and b) The patient has no sensitivity to aspirin.
Altace®f *(ramipril)*	020	Patients with a history of cardiovascular disease.
Ambien® *(zolpidem tartrate)*	006	Treatment of insomnia. Drug therapy is limited to 10 units in 30 days.
Ambien CR® *(zolpidem tartrate)*		See criteria for Ambien®.
Angiotensin Receptor Blockers (ARBs) **Atacand®** *(candesartan cilexetil)* **Atacand HCT®** *(candesartan cilexetil/HCTZ)* **Avalide®** *(irbesartan/HCTZ)* **Avapro®** *(irbesartan)* **Benicar®** *(olmesartan medoxomil)* **Cozaar®** *(losartan potassium)* **Diovan®** *(valsartan)* **Diovan HCT®** *(valsartan/HCTZ)* **Hyzaar®** *(losartan potassium/HCTZ)* **Micardis®** *(telmisartan)* **Micardis HCT®** *(telmisartan/HCTZ)* **Teveten®** *(eprosartan mesylate)* **Teveten HCT®** *(eprosartan mesylate/HCTZ)*	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.

Drug	Code	Criteria
Anzemet® *(dolasetron mesylate)*	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
Arava® *(leflunomide)*	034	Treatment of rheumatoid arthritis when prescribed by a rheumatologist at a loading dose of 100mg per day for three days and then up to 20mg daily thereafter.
Avinza® *(morphine sulfate)*	040	Diagnosis of cancer-related pain.
Calcium w/Vitamin DTablets	126	Confirmed diagnosis of osteoporosis, osteopenia, or osteomalacia.
Campral® *(acamprosate sodium)*	041	Diagnosis of alcohol dependency. Must be used as adjunctive treatment with a Division of Alcohol and Substance Abuse (DASA) state-certified intensive outpatient chemical dependency treatment program. See WAC 388-805-610. Treatment is limited to 12 months. The patient must also meet all of the following criteria: a) Must have finished detoxification and must be abstinent from alcohol before the start of treatment; b) Must not be a poly-substance abuser; and c) Must be able to clear the drug renally (creatinine clearance greater than 30 ml/min). **Note:** A Campral authorization form [DSHS 13-749] must be completed and kept on file with the pharmacy before the drug is dispensed. To download a copy, go to: http://www1.dshs.wa.gov/msa/forms/eforms.html.
Celebrex®	062	All of the following must apply a) An absence of a history of ulcer of gastrointestinal bleeding; and b) An absence of a history of cardiovascular disease.

Drug	Code	Criteria
Clozapine: **Clozaril**®	018	All of the following must apply: a) There must be an appropriate DSM IV diagnosis present as determined by a qualified mental health professional; and b) Patient is 17 years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above.
Concerta® *(methylphenidate HCl)*	026	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and the prescriber is an authorized schedule II prescriber.
Copegus® *(ribavirin)*	010	Diagnosis of chronic hepatitis C virus infection in patients 18 years of age or older. Patient must be on concomitant alpha interferon or pegylated alpha interferon therapy (not to be used as monotherapy).
Coreg® *(carvedilol)*	057	Diagnosis of congestive heart failure.
Dexedrine® *(D-amphetamine sulfate)*		See criteria for Adderall®.
Dextrostat® *(D-amphetamine sulfate)*		See criteria for Adderall®.
Duragesic® *(fentanyl)*	040	Diagnosis of cancer-related pain.
Enbrel® *(etanercept)*	017	Treatment of rheumatoid arthritis or ankylosing spondylitis when prescribed by a rheumatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more Disease Modifying Anti Rheumatoid Drug (DMARD).
	024	Treatment of psoriatic arthritis when prescribed by a rheumatologist or dermatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more DMARD.
	025	Treatment of plaque psoriasis in patients 18 years of age and older when prescribed by a rheumatologist or dermatologist. Dose not to exceed 50mg subcutaneously twice weekly for the first three months of therapy and not to exceed 50mg weekly thereafter.

Drug	Code	Criteria
Kytril® *(granisetron HCl)*	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
	128	Prevention of nausea or vomiting associated with radiation therapy.
Lamisil® *(terbinafine HCl)*		Treatment of onychomycosis for up to 12 months is covered if patient has one of the following conditions:
	042	Diabetic foot;
	043	History of cellulitis secondary to onychomycosis and requiring systemic antibiotic therapy;
	051	Peripheral vascular disease; or
	052	Patient is immunocompromised.
Levorphanol	040	Diagnosis of cancer-related pain.
Lotrel® *(amlodipine-besylate/ benazepril)e*	038	Treatment of hypertension as a second-line agent when blood pressure is not controlled by any: a) ACE inhibitor alone; or b) Calcium channel blocker alone; or c) ACE inhibitor and a calcium channel blocker as two separate concomitant prescriptions.
Lunesta™ *(eszopiclone)*		See criteria for Ambien.®
Lyrica® (*pregabalin*)	035	Treatment of post-herpetic neuralgia.
	036	Treatment of seizures.
	063	Treatment of diabetic peripheral neuropathy.
Metadate CD® *(methylphenidate HCl)*		See criteria for Concerta®
Miralax® *(polyethylene glycol)*		See criteria for Glycolax Powder®
Naltrexone		See criteria for ReVia®.

Drug	Code	Criteria
Nephrocaps®	096	Treatment of patients with renal disease.
Nephro-FER® *(ferrous fumarate/ folic acid)* **Nephro-Vite**® (*vitamin B comp W-C)* **Nephro-Vite RX**® (*folic acid/vitamin B comp W-C)* **Nephro-Vite+FE**® *(fe fumarate/FA/vitamin B comp W-C)* **Nephron FA**®*(fe fumarate/doss/FA/B comp & C)*		
Neurontin® *(gabapentin)*	035	Treatment of Post-herpetic neuralgia.
	036	Treatment of seizures.
	063	Treatment of diabetic peripheral neuropathy
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) Ansaid® *(flurbiprofen).* Arthrotec® *(diclofenac/misoprostol)* Bextra® *(valdecoxib)* Cataflam® *(diclofenac)* Clinoril® *(sulindac)* Daypro® *(oxaprozin)* Feldene® *(piroxicam)* Ibuprofen Indomethacin Lodine®, Lodine XL® *(etodolac)* Meclofenamate Mobic® *(meloxicam)* Nalfon® *(fenoprofen)* Naprelan®, Naprosyn® *(naproxen)* Orudis®, Oruvail® (k*etoprofen*) Ponstel® *(mefenamic acid)* Relafen® *(nabumetone)* Tolectin® *(tolmetin)* Toradol® *(ketorolac)* Vicoprofen® *(ibuprofen/hydrocodone)* Voltaren® *(diclofenac)*	141	An absence of a history of ulcer or gastrointestinal bleeding.

Drug	Code	Criteria
		d) Is not abusing alcohol, benzodiazepines, barbiturates, or other sedative-hypnotics; e) Is not pregnant or nursing; f) Does not have a history of failing multiple previous opioid agonists treatments and multiple relapses; g) Does not have concomitant prescriptions of azole antifungal agents, macrolide antibiotics, protease inhibitors, phenobarbital, carbamazepine, phenytoin, and rifampin, unless dosage adjusted appropriately; and h) Is enrolled in a state-certified intensive outpatient chemical dependency treatment program. See WAC 388-805-610. **Limitations:** • No more than 14-day supply may be dispensed at a time; • Urine drug screens for benzodiazepines, amphetamine/ methamphetamine, cocaine, methadone, opiates, and barbiturates must be done before each prescription is dispensed. ***The prescriber must fax the pharmacy with confirmation that the drug screen has been completed to release the next 14-day supply. The fax must be retained in the pharmacy for audit purposes;*** • Liver function tests must be monitored periodically to guard against buprenorphine-induced hepatic abnormalities; and • Clients may receive up to 6 months of buprenorphine treatment for detoxification and stabilization. **Note:** A Buprenorphine-Suboxone Authorization Form (DSHS 13-720) must be on file with the pharmacy before the drug is dispensed. **To download a copy, go to:** http://www1.dshs.wa.gov/msa/forms/eforms.html.
Symbyax® *(olanzapine/ fluoxetine HCl)*	048	All of the following must apply: a) Diagnosis of depressive episodes associated with bipolar disorder; and b) Patient is **6** years of age or older.
Talacen® *(pentazocine HCl/ acetaminophen)* **Talwin NX**® *(pentazocine/naloxone)*	091	Patient must be **12** years of age or older and has tried and failed two NSAIDs or failed one other narcotic analgesic and is allergic or sensitive to codeine.

Drug	Code	Criteria
Toprol XL® *(metoprolol succinate)*	057	Diagnosis of congestive heart failure.
Topamax®/ Topamax® Sprinkle *(topiramate)*	036	Treatment of Seizures.
	045	Migraine prophylaxis.
Vancomycin oral	069	Diagnosis of clostridium difficile toxin and the patient has failed to respond after 2 days of metronidazole treatment or the patient is intolerant to metronidazole.
Vitamin E	105	Confirmed diagnosis of tardive dyskinesia or is clinically necessary for Parkinsonism and all of the following: a) Caution is addressed for concurrent anticoagulant treatment; and b) Dosage does not exceed 3,000 IU per day.
Wellbutrin SR and XL® *(bupropion HCl)*	014	Treatment of depression.
Xopenex® *(levalbuterol HCl)*	044	All of the following must apply: a) Patient is 6 years of age or older; and b) Diagnosis of asthma, reactive airway disease, or reversible airway obstructive disease; and c) Must have tried and failed racemic generic albuterol; and d) Patient is not intolerant to beta-adrenergic effects such as tremor, increased heart rate, nervousness, insomnia, etc.
Xopenex HFA® *(levalbuterol tartrate)*	044	See criteria for Xopenex.®
Zelnorm® *(tegaserod hydrogen maleate)*	055	Treatment of constipation dominant Irritable Bowel Syndrome (IBS) in ***women*** when the patient has tried and failed at least two less costly alternatives.
	056	Chronic constipation when the patient has tried and failed at least two less costly alternatives.